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AUTHOR Blacher-Dixon, Jan; Simeonsson, Rune J.
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ABSTRACT

The paper demonstrates the potential of sociodramatic and role-taking activities for promoting socially competent behavior in the retarded. Possible applicability of a variety of interventin techniques to different settings or countries is considered. The domains of role-taking and sociodramatic activities are seen to comprise an important and productive area of research with significant clinical implications. The authors suggest that sociodramatic activities become a part of any program for the mentally retarded which has social competence, or some type of normalization, as a goal. (Author/SBH)

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THE DEVELOPMENT OF SOCIAL COMPETENCE THROUGH ROLE-TAKING AND SOCIODRAMATIC ACTIVITIES

Jan Blacher-Dixon
Research Training Fellow

and

Rune J. Simeonsson
Asst. Director Research Training Program
Asst. Prof. Division of Special Education

Frank Porter Graham Child Development Center
University of North Carolina
Chapel Hill, North Carolina 27514

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ABSTRACT

The purpose of this paper is to demonstrate the potential of sociodramatic and role-taking activities for promoting socially competent behavior in the retarded. A conceptual paper, augmented by data collected by the authors and others, will be presented which underscores the importance of social competence and role-taking in mentally retarded individuals and the potential applicability of a variety of intervention techniques to different settings or countries.

The domains of role-taking and sociodramatic activities comprise a potentially important and productive area of research with significant clinical implications. The authors suggest that sociodramatic activities become a part of any program for the mentally retarded which has social competence, or some type of normalization, as a goal.

> Every day the retarded, 20-year-old fellow rode the bus and subway to work, always making the correct transfers and money transactions, and arriving at the factory on time. His work was flawless and, in fact, he was considered a good employee. One day he was fired. For what reason? He failed to notice that two of his supervisors were engaged in conversation, and walked right between them without saying "excuse me."

Clearly, this fellow's failure to be socially aware caused him to behave inappropriately, and cost him his job. All of you who have worked with mentally retarded individuals can probably recall similar situations in which a retarded person behaved awkwardly in a certain social situations by failing to make correct inferences (or any inferences!) about the situation and people present. Such inferences about others are important, because they influence interpersonal relationships. It is well-known that retarded individuals often show deficits in their conceptual-inferential processes, consequently demonstrating a lack of social competence in common daily situations. Thus, developing social competence and social awareness is even more critical in areas where the retarded are integrated into general community life via such principles as mainstreaming or normalization.

The purpose of this paper is to demonstrate, in general terms, how certain experimental or therapeutic procedures can promote the development of socially competent behavior. One such procedure is the experimental manipulation of role-taking activities through which the subject recognizes that other people have views or perspectives different from their own, thus learning to "take the role of another." Another procedure involves the use of sociodramatic activities, in which the subject actually is asked to "play" different roles in order to learn appropriate behavior, improve interpersonal relationships, and enhance personality development.

The following three separate areas of research with the retarded will be reviewed in this presentation: (1) social competence, which actually refers to competence in the area of personal and social development; (2) social cognitive development, which includes a number of specific cognitive skills important for developing social awareness; and (3) sociodramatic activities, techniques often employed to obtain therapeutic goals.

The reason for focusing on these three areas of research is to more clearly operationalize the concept of social competence. Presently, social competence is a term used frequently with respect to the retarded, and its definition has often been linked to specific studies and instruments. Evidence for current interest in the social competence of the developmentally disabled is reflected by the substantial growth of attention devoted to this topic in the professional literature. The timeliness of such interest has been indicated by Kleck (1975) and Affleck (1977) who stressed that social incompetence has been a concept central to defining mental retardation from a practical as well as historical standpoint. The fact that social competence has only recently become a topic for thorough research and application is surprising since Tredgold (1937) and Doll (1953) dealt with this concept several decades ago, and Heber (1959) introduced adaptive behavior and its social dimensions as an additional basis for the classification of mental retardation in 1959.

There are a number of ways of looking at socially competent behavior. An overview of the literature indicates that social competence has been defined in variety of ways and equated with a variety of behaviors. The early work of Doll (1953) seems to equate social competence with social maturity. Secondly, a substantial body of literature identified vocational or occupational adjustment as a perspective for social competence. In a recent publication, O'Malley (1977) proposed three additional ways in which

social competence could be viewed, that is, adaptive behavior, instrumental competence and interpersonal competence. These five approaches each seem to define social competence from a unique perspective and were adopted by Simeonsson (in press) as a framework for examining definitions and assessments of social competence in retarded persons.

In this presentation, we will focus on the interpersonal competence approach to defining socially competent behavior, which involves a number of interpersonal and cognitive skills. What are the essential ingredients of this approach? O'Malley (1977) has suggested that social contracts are critical for developing interpersonal competence. Weinstein's (1975) theory of interpersonal competence emphasizes three components of socially competent behavior: (a) to be able to take the role of the other in social situations; (b) to have a range of interpersonal tactics; and (c) to be able to implement these tactics when appropriate. Consider once again the retarded fellow in our opening story. If he had (a) taken the role of one or both of his supervisors and realized that they were talking and did not want to be interrupted; (b) examined his alternatives, such as waiting until they were finished talking, walking around them, or saying "excuse me" when passing between them; and (c) acted according to one of these strategies, he probably would not have lost his job.

Adopting Weinstein's approach, it is clear that skills such as taking the role of another and communicating effectively are important. These skills have been investigated in social-cognitive research which includes the dimensions of role-taking, empathy, moral judgment, and referential communication. Although Piaget's concepts of egocentrism and decentration are central to research on social cognitive development, a number of investigators have extended and elaborated upon this area of research. For example, Shantz (1975)

recently published a comprehensive review of the literature in which she elaborately defined social cognition as "the child's intuitive or logical representation of others, that is, how he characterizes others and makes inferences about their covert inner psychological experiences." (p. 258).

Merging Weinstein's theory with research on social-cognitive skills thus provides some specific ways in which to operationalize the assessment of interpersonal competence in the retarded. For example, the use of role-taking tasks can be used to assess how the retarded person establishes identities in social encounters. Such research relevant to the development of social cognition in retarded individuals has recently emerged in the professional literature. In general, this research can be summarized as follows: (1) Role-taking ability is an important determinant of interpersonal tactics. For example, Affleck (1976) has shown that individuals who performed well on taking the role of others used better strategies for solving an interpersonal task. (2) Role-taking may also be related to communicative effectiveness in children. In a series of studies, Longhurst (1974) demonstrated that the retarded child's ability to communicate is not simply a function of vocabulary or IQ, but of perspective-taking ability as well. Employing a speaker-listener paradigm for referential communication, Longhurst (1972) found that mentally retarded adolescents could follow their own instructions, but were inadequate in their communication to others. The retarded adolescents thus demonstrated their failure to take into account the listener's needs, despite the fact that they had demonstrated the possession of appropriate communication skills. (3) There have also been studies of the retarded person's ability to take into account the intents and consequences of another person's behavior. In recent research on moral

judgment, Simeonsson and Foye (1975) found that the moral judgment of the retarded is generally delayed, but characterized by individual variability. Hence, some retarded individuals are "competent" and some are not in making moral judgments involving differential intent and consequence. Based on these research findings, it can be concluded that: (1) social cognitive skills are not determined solely by intelligence level; (2) component skills of social cognition, e.g., role-taking, communication, moral judgment, are related to socially competent behavior; and (3) the role of experience appears to be critical in the development of these skills.

These facts seem to indicate that a person who is intellectually retarded does not necessarily have to be socially incompetent. Research has shown that some retarded individuals do possess the necessary component skills for performing competently in interpersonal situations. Such variability in role-taking skills among the retarded cannot be explained by level of intelligence alone, but may depend on the types of experiences they have had. This suggests that specific interventions to enhance role-taking behavior would be effective. Some of these interventions have been demonstrated; others need further exploration. The major evidence supporting intervention to promote social competence comes from experimental studies and from clinical reports.

In one role-taking intervention study by Blacher-Dixon and Simeonsson (in press), retarded children of comparable intelligence and age were grouped according to high, intermediate or low role-taking ability. An experimental task, in which children were required to adopt perspectives or viewpoints different from their own, i.e., to "stand in the shoes of another person," was then administered to promote role-taking performance. The procedure was found to be differentially effective, in that the performance of the high and

low groups remained unchanged across two testings, whereas the intermediate group improved after the experimental intervention. We are currently testing the long-range effects of this "mini-intervention" to determine whether the experimentally manipulated intervention, some broader type of experience, or maturity can account for the improved role-taking performance (Blacher-Dixon and Simeonsson, in preparation).

A more general type of intervention was carried out by Chandler, Greenspan and Barenboim (1974) with 48 institutionalized emotionally disturbed children who were shown by screening procedures to be deficient in role-taking and communication. One third of the subjects were enrolled in a 10-week training program which used drama and the making of video films as vehicles for teaching role-taking skills; another third were involved in a 10-week training program which used communication games in order to improve their referential communication skills; the last group was the no treatment control group. Subjects in both experimental groups improved significantly in their role-taking ability and subjects who received the communication training showed improvement in their communication skills as well. Of particular significance is the fact that a 12-month follow-up showed that such improvements were associated with improvements in social adjustment. Similar findings on the effectiveness of intervention have also been found with chronically delinquent boys initially deficient in role-taking skills (Chandler, 1973).

The second major strategy to promote social competence is based on clinical reports using sociodramatic activities. The use of sociodramatic activities as a vehicle for social development has been proposed specifically for the mentally retarded (Foster, 1975). A creative dramatics workshop described by Blumberg (1976) was designed to enhance personality and social development of

the mentally retarded with an ultimate goal of improving job potential. The advantages of using role play to develop social interaction and appropriate job behavior have been cited by Robinson (1970) from experiences in classes with retarded adolescent girls. Although the application of sociodramatic activities may seem more appropriate to older children or adults, its effectiveness with severely retarded preschoolers has also been demonstrated. Strain (1975) observed social play and suggested that the participation in sociodramatic activities was associated with increased social play. In summary, the experimental studies in role-taking previously mentioned represent very specific types of interventions, whereas the use of sociodramatic activities contribute to a more global type of intervention.

In conclusion, there is clinical as well as empirical support for enhancing the development of social competence in retarded individuals through sociodramatic activities and role-taking training. The methodologies available are clearly applicable for future intervention and represent a potentially important and productive area of research with significant clinical implications. There are three essential points to keep in mind: (1) Social experience, by itself, is not sufficient for developing social competence. Mentally retarded individuals must <u>actively</u> assume the roles of others and <u>actively</u> solve various social dilemmas. Too often retarded persons are sheltered from such critical, "real world" experiences. (2) Role-taking and sociodrama provide vehicles for systematically building in social competence skills. (3) We advocate the inclusion of sociodramatic activities as part of any training program for the mentally retarded. In short, "a person cannot take a role for which he has no knowledge of its attributes and expectations." (Volpe, 1976, p. 372). The principle of normalization advocates

for opportunities in which mentally retarded can assume the roles, take the risks and make the choices which foster socially competent behavior. We can, and should, optimize those opportunities.

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